KAO PEDIATRIC DENTISTRY

1) Tell Us About Your Child

Child's Name: _____ **Nickname:** _____
First Last

Primary Contact #: (_____) _____ - _____ **Birthdate:** ____/____/_____ **Child's Age:** _____ ☐ Male ☐ Female

Child's Home Address: _____
Number Street Apt # City State Zip

2) Parent's Information

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Mother ☐ Father ☐ Guardian ☐ Step Parent

Name: _____ **Birthdate:** ____/____/_____

Email: _____

Employer: _____

Cell #: (_____) _____ - _____ **Work #:** (_____) _____ - _____

Address (if different): _____
Number Street Apt #

_____
City State Zip

If you have Dental Insurance Coverage for your Child, please fill out below:

Insurance Co. Name: _____

SSN: _____ **Member ID:** _____

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Mother ☐ Father ☐ Guardian ☐ Step Parent

Name: _____ **Birthdate:** ____/____/_____

Email: _____

Employer: _____

Cell #: (_____) _____ - _____ **Work #:** (_____) _____ - _____

Address (if different): _____
Number Street Apt #

_____
City State Zip

If you have Dental Insurance Coverage for your Child, please fill out below:

Insurance Co. Name: _____

SSN: _____ **Member ID:** _____

3) Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent/ Legal Guardian Signature: _____ **Date:** _____/_____/_____

4) General Information

Who is accompanying the child on the first visit? _____ **Relation:** _____ **Do you have legal custody of this child?** ☐ Yes ☐ No

Reason for this visit: _____ **How did you find out about our office?** _____

Previous Dentist: _____ **Last Visit:** _____/_____/_____ **Dentist Phone #:** (_____) _____ - _____

Emergency Contact Name (other than parents): _____ **Emergency Contact Phone #:** (_____) _____ - _____

5) Acknowledgement of Receipts of Dental Materials Fact Sheet Privacy Practices Notice

I acknowledge that the New Dental Materials Fact Sheet dated May 2004 and Privacy Practices Notice is available upon request. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

Parent/ Legal Guardian Signature: _____ **Date:** _____/_____/_____

Child's Name: _____ **DOB:** ___/___/_____

6) Dental History

Type of Water Source: ☐ City Water ☐ System ☐ Private Well ☐ Filtered/ Bottled Water

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If not, when was the last visit? _____

*Were x-rays taken at that visit? ☐ Yes ☐ No

Has your child had a negative dental experience? ☐ Yes ☐ No

Did your child nurse or use a bottle after 12 months? ☐ Yes ☐ No

Did your child nurse or use a bottle throughout the night? ☐ Yes ☐ No

Do you assist your child's brushing? ☐ Yes ☐ No

Does your child have any habits? (Thumb sucking, pacifier, etc.)

☐ Yes ☐ No *If yes, please list: _____

Does your child drink juice or soda? ☐ Yes ☐ No

*If yes, how much a day? _____

Does your child snack throughout the day? ☐ Yes ☐ No

Has your child had any type of oral pain recently? ☐ Yes ☐ No

Has your child ever had a dental injury? ☐ Yes ☐ No

*If yes, please explain: _____

Has your child ever been prescribed Fosamax or any other bisphosphonate? *If yes, when? _____ ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

How many times a day does your child brush? _____

How many times a day does your child floss? _____

7) Medical History

Pediatrician Name: _____

Phone #: (_____) _____ -_____ **Date of Last Visit:** _____

Are the child's immunizations current? ☐ Yes ☐ No

Please list any medications your child is taking: _____

_____

Please list **ANY** allergies: _____

_____

Has your child experienced the following medical problems? **(Do not leave blank)**

☐ Yes ☐ No	**ADD/ ADHD**	☐ Yes ☐ No	**Fainting**
☐ Yes ☐ No	**Anemia**	☐ Yes ☐ No	**Heart Problem**
☐ Yes ☐ No	**Anxiety/ Depression**	☐ Yes ☐ No	**Heart Murmur**
☐ Yes ☐ No	**Asthma**	☐ Yes ☐ No	**HIV/AIDS**
☐ Yes ☐ No	**Autism Spectrum**	☐ Yes ☐ No	**Kidney Disease**
☐ Yes ☐ No	**Bisphosphonates**	☐ Yes ☐ No	**Latex Allergy**
☐ Yes ☐ No	**Bleeding Disorder**	☐ Yes ☐ No	**Liver Disease**
☐ Yes ☐ No	**Cerebral Palsy**	☐ Yes ☐ No	**Malignancies**
☐ Yes ☐ No	**Chronic Sinusitis**	☐ Yes ☐ No	**Rheumatoid Arthritis**
☐ Yes ☐ No	**Deaf**	☐ Yes ☐ No	**Sensory Issues**
☐ Yes ☐ No	**Developmental Delay**	☐ Yes ☐ No	**Speech Delay**
☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Thyroid Problem**
☐ Yes ☐ No	**Down Syndrome**	☐ Yes ☐ No	**Tuberculosis**
☐ Yes ☐ No	**Epilepsy/ Seizures**	☐ Yes ☐ No	**Visual Impairment**

Please discuss **any** serious medical problems, hospitalizations, surgeries your child has experienced:

_____

_____

_____

TO THE BEST OF MY KNOWLEDGE, THE ANSWERS I HAVE GIVEN ARE ACCURATE. I UNDERSTAND THAT IT IS IMPORTANT TO REPORT CHANGES IN MY CHILD'S MEDICAL OR DENTAL STATUS TO THE DENTIST, AND I AGREE TO DO SO. I GIVE PERMISSION TO THE DENTIST TO OBTAIN ADDITIONAL INFORMATION FROM MY CHILD'S PHYSICIAN REGARDING MEDICAL HISTORY NEEDED TO PROVIDE DENTAL TREATMENT.

Parent/ Legal Guardian Signature:_____ **Date:** _____/_____/_____

FOR OFFICE USE ONLY. PLEASE KEEP THE REST OF THE PAGE BLANK.

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Doctor Signature: _____ Date: ____/____/_____

MEDICAL HISTORY UPDATE

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

_____ ___/___/_____ _____ _____/_____/_____

Parent Signature Date Doctor Signature Date

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

_____ ___/___/_____ _____ _____/_____/_____

Parent Signature Date Doctor Signature Date

Child's Name: _____ DOB: ___/___/_____

8) Policies and Agreements

Appointment Cancellations: Our team is dedicated to providing excellent dental care to all of our patients. When an appointment is scheduled, that date and time is specifically reserved for your child. Missing an appointment prevents us from offering that time to another patient. We kindly ask for a **48 business hour notic**e if you need to cancel an appointment. Our appointment policy are as follows:

- Failure to show up or late cancellations made with less than **48 business hours notice** will result in a **$50 fee per visit, per child.**
- Patients who repeatedly miss appointments may be required to pay a $50 deposit, which will be applied to the cost of the visit.
- **Patients who miss more than two appointments may be subject to dismissal from our practice.**

Outstanding Balances: It is our office policy that any outstanding copays be paid in full. A finance charge of 1.5% will be assessed and appear on your statement if your account is delinquent over 90 days (18% APR). Failure to make payments on time may result in suspension of future dental appointments until balance is made or additional fees may apply for late or missed payments as outlined above.

Insurance Disclaimer: Insurance is a contract between you and your insurance company. We are **NOT** a party in this contract. We file claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc. other than to supply factual information as necessary.

Payment as Services are Rendered: *Your co-pay is due at the time the services are rendered.* Because your insurance company makes no guarantee of payment, for this reason we can only provide you with an estimate of your insurance coverage. Therefore, you may receive a statement with an additional balance after your insurance has met their obligation. We ask that your portion be paid at the service or within fifteen (15) days of receiving such a statement. **If your insurance does not allow assignment of benefits, you will be required to pay the treatment in full.** Our office realizes that some families are within a state of change and on occasion question who is responsible for the bill. *Ultimately, the parent who requests the dental services will be responsible for the fees incurred.*

Follow-Up Dental Care: No healthcare provider can provide guarantees regarding treatment success. We feel that to increase your child's chances of long term success, we recommend that you follow up with regular check-ups every 3 or 6 months, complete proposed treatment, brush and floss twice a day, and encourage a proper diet. In doing so, you are giving your child the best possible opportunity to achieve long-term oral health.

We accept cash, Visa, Discover, Master Card, FSA, HSA, and Care Credit.

Parent/ Legal Guardian Signature: _____ Date: _____/_____/_____

9) Informed Consent for Routine Dental Procedures

As the parent/legal guardian, you have the right to accept or reject dental treatment recommended by the dentist. Do not consent to treatment until you discuss potential benefits, risks, and complications with your child's dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and common risks of the recommended procedure, alternative treatment, and the option of no treatment. By consenting to treatment, you acknowledge your willingness to accept the risks and complications, no matter how slight the probability of occurrence.

Treatment to be provided: I understand that during my child's course of treatment the following may be provided: Examinations, preventative services (fluoride, sealants, and space maintainers), restorations (fillings), crowns, and radiographs (x-rays). I will be consulted prior to each appointment.

Drugs and medications: I understand that antibiotics, analgesia, anesthetic agents and other medications may cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction).

Changes in treatment plan: I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination. The most common changes are root canal therapy and extraction, following routine restorative procedures. I give my permission to my child's dentist to make any/all changes and additions as necessary. I understand that I will be consulted regarding changes whenever possible.

Parent/ Legal Guardian Signature: _____ Date: _____/_____/_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OHSA, the CDC, and the ADA.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain Payments from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I may request the Notice of Privacy Practices containing a more complete description of uses and disclosures of my child's health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that the office may restrict how your child's private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the dental office is not required to agree to my requested restrictions; However, if you agree, that you are bound by such restrictions. I understand that I have the right to revoke this consent except to the extent that we have already acted covered under this consent.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

Parent/ Legal Guardian Signature: _____ Date: _____/_____/_____